

Submitter : Ms. Penny Sanchez
Organization : National Medicaid EDI HIPAA Workgroup
Category : State Government

Date: 01/20/2006

Issue Areas/Comments

GENERAL

GENERAL

Recently the National Medicaid EDI HIPAA Workgroup (NMEH) initiated a brief survey to provide feedback to the department about claims attachments. Only 11 states responded making this response statistically weak; therefore, I am sending the individual state responses instead of aggregating the information so the department, at a minimum, has the original data from the states.

CMS-0050-P-92-Attach-1.DOC

CMS-0050-P-92-Attach-10.DOC

CMS-0050-P-92-Attach-11.DOC

CMS-0050-P-92-Attach-2.DOC

CMS-0050-P-92-Attach-3.DOC

CMS-0050-P-92-Attach-4.DOC

CMS-0050-P-92-Attach-5.DOC

CMS-0050-P-92-Attach-6.DOC

CMS-0050-P-92-Attach-7.DOC

CMS-0050-P-92-Attach-8.DOC

CMS-0050-P-92-Attach-9.DOC

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	January 12, 2006
State	Alabama
Contact Name	Cathy G. Brown
Contact Phone	334-242-5627
Contact e-mail Address	cbrown@medicaid.state.al.us

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
x	500,001 – 1,000,000
	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

x	Less than 1%
	1 – 5%
	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

x	837P
x	837I
x	837D
x	835
x	270/271
x	276/277
x	278 Request and Response
	834
	820
x	997
	999
	824
x	NCPDP Claims
	NCPDP Prior Authorization
x	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

x	837P
x	837I
x	837D
x	835
x	227/271
x	276/277
x	278 Request and Response
	834
	820
x	997
	999
	824
x	NCPDP Claims
	NCPDP Prior Authorization
x	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results						x
Non-RX Meds						x
Clinical Reports						x
Alcohol-Substance Abuse Rehab						x
Cardiac Rehab						x
Medical Social Svcs Rehab						x
Occupational Rehab						x
Physical Therapy Rehab						x
Speech Therapy Rehab						x
Respiratory Rehab						x
Skilled Nursing Rehab						x
Psychiatric Rehab						x
Emergency Department						x
Ambulance Services						x
DME						x
Home Health						x
Periodontal Charting						
Children Preventive Health Services						x
Consent (Abortion, Hyst, Sterilization)	x					
Dental X-Rays						x
Non-Ambulance Transportation						x
Eligibility/Spenddown						x
Medical Supplies						x
Compound Drugs						x

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

If a third party insurance denies payment, Alabama requires proof of denial.

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

<input type="checkbox"/>	Solicited
<input type="checkbox"/>	Unsolicited
<input checked="" type="checkbox"/>	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

<input checked="" type="checkbox"/>	Federal Mandate
<input checked="" type="checkbox"/>	State Mandate
<input type="checkbox"/>	Medical Policy
<input checked="" type="checkbox"/>	Federal or State Reporting Requirement
<input type="checkbox"/>	Fraud and Abuse Mitigation
<input type="checkbox"/>	Quality Measurements
<input type="checkbox"/>	Pay for Performance Measures
<input checked="" type="checkbox"/>	Other, Please state: Third Party Denials

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image						x
Scan and Save as Text via OCR						
Save as Paper						
Manually Key Data from Hard Copy						
Save in Other Electronic Media (word, pdf, etc)						
Discard/Destroy the Paper	x					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	12/30/2005
State	California
Contact Name	Penny Sanchez
Contact Phone	916-636-1168
Contact e-mail Address	Penny.sanchez@eds.com

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
	1M – 5M
	5M – 10M
X	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
	1 – 5%
	5 – 10%
	11 - 20%
X	21 – 30% (70% for dental claims which equals 9% of the total claim volume)
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	270/271
X	276/277
	278 Request and Response
	834
	820
X	997
	999
	824
X	NCPDP Claims
X	NCPDP Prior Authorization
	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	270/271
X	276/277
	278 Request and Response
	834
	820
X	997
	999
	824
X	NCPDP Claims
X	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results		X				
Non-RX Meds			X			
Clinical Reports		X				
Alcohol-Substance Abuse Rehab		X				
Cardiac Rehab		X				
Medical Social Svcs Rehab		X				
Occupational Rehab				X		
Physical Therapy Rehab		X		X		
Speech Therapy Rehab				X		
Respiratory Rehab				X		
Skilled Nursing Rehab		X				
Psychiatric Rehab		X				
Emergency Department		X				
Ambulance Services		X				
DME		X				
Home Health		X				
Periodontal Charting		X				
Children Preventive Health Services		X				
Consent (Abortion, Hyst, Sterilization)	X					
Dental X-Rays		X				??
Non-Ambulance Transportation		X				
Eligibility/Spenddown				X		
Medical Supplies		X				Checking with Maureen
Compound Drugs			X			Checking with Maureen

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

Manufacturer catalog pages (DME)
Medical Necessity Justification
Other Health Coverage Information

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

X	Solicited
	Unsolicited
	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

X	Federal Mandate
X	State Mandate
X	Medical Policy
X	Federal or State Reporting Requirement
X	Fraud and Abuse Mitigation
X	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR						
Save as Paper						
Manually Key Data from Hard Copy						
Save in Other Electronic Media (word, pdf, etc)						
Discard/Destroy the Paper						

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	12/20/05
State	Delaware
Contact Name	Lisa Bond
Contact Phone	302-255-9765
Contact e-mail Address	Lisa.bond@state.de.us

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
X	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
	1 – 5%
	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
X	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	2270/271
X	276/277
X	278 Request and Response
X	834
X	820
X	997
?	999
?	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	2270/271
X	276/277
X	278 Request and Response
X	834
X	820
X	997
?	999
?	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results		X				
Non-RX Meds		X				
Clinical Reports			X			
Alcohol-Substance Abuse Rehab				X		
Cardiac Rehab				X		
Medical Social Svcs Rehab				X		
Occupational Rehab				X		
Physical Therapy Rehab				X		
Speech Therapy Rehab				X		
Respiratory Rehab				X		
Skilled Nursing Rehab					X	
Psychiatric Rehab			X			
Emergency Department		X				
Ambulance Services			X			
DME		X				
Home Health			X			
Periodontal Charting			X			
Children Preventive Health Services				X		
Consent (Abortion, Hyst, Sterilization)	X					
Dental X-Rays			X			
Non-Ambulance Transportation						X
Eligibility/Spenddown						X
Medical Supplies			X			
Compound Drugs			X			

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

	Solicited
	Unsolicited
X	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

X	Federal Mandate
X	State Mandate
X	Medical Policy
X	Federal or State Reporting Requirement
X	Fraud and Abuse Mitigation
X	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR						X
Save as Paper	X					
Manually Key Data from Hard Copy			X			
Save in Other Electronic Media (word, pdf, etc)						X
Discard/Destroy the Paper	X					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	12/29/05
State	Illinois
Contact Name	Steve Poelsterl
Contact Phone	312-814-6817
Contact e-mail Address	AIDD1221@IDPA.STATE.IL.US

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
	1M – 5M
X	5M – 10M Claim count
X	More than 10M Service count

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
X	1 – 5%
	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D – Dental Administrator will begin submitting enc data 01/01/06
X	835 (For Institutional claims only)
X	270/271
X	276/277
	278 Request and Response
X	834
X	820
X	997
	999
X	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D– Dental Administrator will begin submitting enc data 01/01/06
X	835 (For Institutional claims only)
X	270/271
X	276/277
	278 Request and Response
X	834
X	820
X	997
	999
X	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	2270/271
X	276/277
X	278 Request and Response
X	834
X	820
X	997
X	999
X	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	2270/271
X	276/277
X	278 Request and Response
X	834
X	820
X	997
X	999
X	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results					X	
Non-RX Meds					X	
Clinical Reports			X			
Alcohol-Substance Abuse Rehab					X	
Cardiac Rehab					X	
Medical Social Svcs Rehab						
Occupational Rehab					X	
Physical Therapy Rehab					X	
Speech Therapy Rehab					X	
Respiratory Rehab					X	
Skilled Nursing Rehab				X		
Psychiatric Rehab					X	
Emergency Department				X		
Ambulance Services				X		
DME		X				
Home Health				X		
Periodontal Charting					X	
Children Preventive Health Services					X	
Consent (Abortion, Hyst, Sterilization)	X					
Dental X-Rays					X	
Non-Ambulance Transportation					X	
Eligibility/Spenddown					X	
Medical Supplies					X	
Compound Drugs				X		

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 6. List any other attachment types not mentioned above that you frequently request.**

- 7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)**

	Solicited
X	Unsolicited
	Both

- 8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)**

X	Federal Mandate
	State Mandate
X	Medical Policy
	Federal or State Reporting Requirement
	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR					X	
Save as Paper					X	
Manually Key Data from Hard Copy			X			
Save in Other Electronic Media (word, pdf, etc)					X	
Discard/Destroy the Paper	X					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	
State	Louisiana
Contact Name	
Contact Phone	
Contact e-mail Address	

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
X	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
	1 – 5%
	5 – 10%
X	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
	2270/271
	276/277
	278 Request and Response
	834
	820
	997
	999
	824
	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
	2270/271
	276/277
	278 Request and Response
	834
	820
	997
	999
	824
	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type		Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results				X			
Non-RX Meds	N/A						
Clinical Reports				X			
Alcohol-Substance Abuse Rehab	N/A						
Cardiac Rehab	N/A						
Med Social Svcs Rehab	N/A						
Occupational Rehab	PA						
Physical Therapy Rehab	PA						
Speech Therapy Rehab	PA						
Respiratory Rehab	N/A						
Skilled Nursing Rehab	N/A						
Psychiatric Rehab	N/A						
Emergency Department	N/A						
Ambulance Services	(AIR)	X					
DME	PA						
Home Health					X		
Periodontal Charting	PA						
Children Preventive Health Services		X					
Consent (Abortion, Hyst, Sterilization)		X					
Dental X-Rays	PA						
Non-Ambulance Transportation					X		
Eligibility/Spenddown		X					
Medical Supplies	PA						
Compound Drugs	N/A						

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

	Solicited
X	Unsolicited
	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

	Federal Mandate
X	State Mandate
X	Medical Policy
	Federal or State Reporting Requirement
	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR						
Save as Paper	X					
Manually Key Data from Hard Copy						
Save in Other Electronic Media (word, pdf, etc)						
Discard/Destroy the Paper	X					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	12-13-05
State	Michigan
Contact Name	Susan Klein
Contact Phone	517-589-5676
Contact e-mail Address	KleinS3@Michigan.gov

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
x	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
x	1 – 5%
	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

x	837P
x	837I
x	837D
x	835
x	2270/271
x	276/277
x	278 Request and Response
x	834
x	820
x	997
	999
	824
x	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

x	837P
x	837I
x	837D
x	835
x	2270/271
	276/277
	278 Request and Response
x	834
x	820
x	997
	999
	824
x	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results				x		
Non-RX Meds			x			
Clinical Reports			x			
Alcohol-Substance Abuse Rehab			x			
Cardiac Rehab			x			
Medical Social Svcs Rehab					x	
Occupational Rehab					x	
Physical Therapy Rehab					x	
Speech Therapy Rehab					x	
Respiratory Rehab					x	
Skilled Nursing Rehab					x	
Psychiatric Rehab					x	
Emergency Department			x			
Ambulance Services			x			
DME			x			
Home Health			x			
Periodontal Charting					x	
Children Preventive Health Services					x	
Consent (Abortion, Hyst, Sterilization)	x					
Dental X-Rays					x	
Non-Ambulance Transportation			x			
Eligibility/Spenddown			x			
Medical Supplies			x			
Compound Drugs	x					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 6. List any other attachment types not mentioned above that you frequently request.**

- 7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)**

	Solicited
x	Unsolicited
	Both

- 8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)**

x	Federal Mandate
x	State Mandate
x	Medical Policy
x	Federal or State Reporting Requirement
x	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	x					
Scan and Save as Text via OCR						
Save as Paper			x			
Manually Key Data from Hard Copy						
Save in Other Electronic Media (word, pdf, etc)						
Discard/Destroy the Paper	x					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	12-19-05
State	Minnesota
Contact Name	Barb Hollerung
Contact Phone	651-431-3180
Contact e-mail Address	<u>Barb.hollerung@state.mn.us</u>

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
X	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
	1 – 5%
X	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	270/271
	276/277
	278 Request and Response
X	834
X	820
X	997
	999
	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	270/271
	276/277
	278 Request and Response
X	834
X	820
X	997
	999
	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results					X	
Non-RX Meds		X				
Clinical Reports		X				
Alcohol-Substance Abuse Rehab					X	
Cardiac Rehab					X	
Medical Social Svcs Rehab				X		
Occupational Rehab				X		
Physical Therapy Rehab				X		
Speech Therapy Rehab				X		
Respiratory Rehab				X		
Skilled Nursing Rehab					X	
Psychiatric Rehab				X		
Emergency Department				X		
Ambulance Services		X				
DME		X				
Home Health				X		
Periodontal Charting					X	
Children Preventive Health Services					X	
Consent (Abortion, Hyst, Sterilization)	X					
Dental X-Rays					X	
Non-Ambulance Transportation			X			
Eligibility/Spenddown			X			
Medical Supplies		X				
Compound Drugs				X		

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 6. List any other attachment types not mentioned above that you frequently request.**

- 7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)**

	Solicited
X	Unsolicited
	Both

- 8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)**

X	Federal Mandate
X	State Mandate
X	Medical Policy
	Federal or State Reporting Requirement
	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR	X					
Save as Paper					X	
Manually Key Data from Hard Copy		X				
Save in Other Electronic Media (word, pdf, etc)					X	
Discard/Destroy the Paper	X					

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	December 29, 2005
State	Missouri
Contact Name	Betty Emmerich
Contact Phone	573/526-4385
Contact e-mail Address	<u>Betty.Emmerich@dss.mo.gov</u>

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
	500,001 – 1,000,000
	1M – 5M
X	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
	1 – 5%
X	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	270/271
X	276/277
	278 Request and Response
X	834
X	820
X	997
	999
	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	2270/271
X	276/277
	278 Request and Response
X	834
X	820
X	997
	999
	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results						X
Non-RX Meds						X
Clinical Reports			X			
Alcohol-Substance Abuse Rehab						X
Cardiac Rehab						X
Medical Social Svcs Rehab						X
Occupational Rehab				X		
Physical Therapy Rehab				X		
Speech Therapy Rehab				X		
Respiratory Rehab						X
Skilled Nursing Rehab						X
Psychiatric Rehab			X			
Emergency Department						X
Ambulance Services		X				
DME			X			
Home Health	X					
Periodontal Charting						X
Children Preventive Health Services						X
Consent (Abortion, Hyst, Sterilization)	X					
Dental X-Rays				X		
Non-Ambulance Transportation						X
Eligibility/Spendedown		X				
Medical Supplies			X			
Compound Drugs				X		

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

Invoice of Cost
Admission History
Admit or Discharge Records
Anesthesia Reports
Consultation Reports
Pathology Reports
Ultrasound Reports
Radiologist Reading

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

	Solicited
X	Unsolicited
	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

X	Federal Mandate
	State Mandate
X	Medical Policy
	Federal or State Reporting Requirement
X	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR						
Save as Paper						
Manually Key Data from Hard Copy						
Save in Other Electronic Media (word, pdf, etc)	X					
Discard/Destroy the Paper						

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	December 28, 2005
State	Utah
Contact Name	Vicky Pierce
Contact Phone	801-532-7939
Contact e-mail Address	vickypierce@utah.gov

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
X	500,001 – 1,000,000
	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

X	Less than 1%
	1 – 5%
	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	270/271
X	276/277
	278 Request and Response
X	834
X	820
X	997
	999
	824
X	NCPDP Claims
X	NCPDP Prior Authorization
X	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	270/271
X	276/277
	278 Request and Response
X	834
X	820
X	997
	999
	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

X = Claims

• = Prior Authorization

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results					X	
Non-RX Meds					X	
Clinical Reports		•	X			
Alcohol-Substance Abuse Rehab					X	
Cardiac Rehab					X	
Medical Social Svcs Rehab					X	
Occupational Rehab		•			X	
Physical Therapy Rehab		•			X	
Speech Therapy Rehab		•			X	
Respiratory Rehab					X	
Skilled Nursing Rehab	•				X	
Psychiatric Rehab			•		X	
Emergency Department				X		
Ambulance Services			•		X	
DME	•			X		
Home Health	•				X	
Periodontal Charting						
Children Preventive Health Services				X		
Consent (Abortion, Hyst, Sterilization)	• X					
Dental X-Rays			•		X	
Non-Ambulance Transportation					X	
Eligibility/Spenddown					X	
Medical Supplies			•	X		
Compound Drugs					X	

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

	Solicited
	Unsolicited
X	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

X	Federal Mandate
X	State Mandate
X	Medical Policy
	Federal or State Reporting Requirement
	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
	Other, Please state:

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

- 9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)**

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	X					
Scan and Save as Text via OCR					X	
Save as Paper					X	
Manually Key Data from Hard Copy				X		
Save in Other Electronic Media (word, pdf, etc)					X	
Discard/Destroy the Paper					X	

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

Demographic Information:

Date Sent	01/06/2006
State	WV
Contact Name	Sue Thompson
Contact Phone	304-558-1752
Contact e-mail Address	sthompson@wvdhhr.org

1. What are the total number of claims received on a monthly basis? (PICK ONE)

	Less than 10,000
	10,001 – 50,000
	50,001-500,000
x	500,001 – 1,000,000
	1M – 5M
	5M – 10M
	More than 10M

2. Approximately what percentage of claims require additional documentation (attachments) in order to be processed? (PICK ONE)

	Less than 1%
x	1 – 5%
	5 – 10%
	11 - 20%
	21 – 30%
	31 – 50%
	More than 50%

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

3. Please check all the X12N Transactions you have implemented.

X	837P
X	837I
X	837D
X	835
X	270/271
X	276/277
	278 Request and Response
	834
	820
X	997
	999
X	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

4. Please check all the X12N Transaction where you currently have active trading partners.

X	837P
X	837I
X	837D
X	835
X	2270/271
X	276/277
	278 Request and Response
	834
	820
X	997
	999
X	824
X	NCPDP Claims
	NCPDP Prior Authorization
	NCPDP Eligibility

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

5. For each claim/attachment type listed below, rate the frequency the health plan requests or requires that they be submitted to pay a claim. If a row does not apply, check N/A.

Attachment Type	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Lab Results				X		
Non-RX Meds			X			
Clinical Reports			X			
Alcohol-Substance Abuse Rehab					x	
Cardiac Rehab						X
Medical Social Svcs Rehab						X
Occupational Rehab						X
Physical Therapy Rehab						X
Speech Therapy Rehab						X
Respiratory Rehab						X
Skilled Nursing Rehab						X
Psychiatric Rehab						X
Emergency Department				X		
Ambulance Services				X		
DME			x			
Home Health					x	
Periodontal Charting						x
Children Preventive Health Services					x	
Consent (Abortion, Hyst, Sterilization)	X*					
Dental X-Rays					x	
Non-Ambulance Transportation						x
Eligibility/Spenddown	x					
Medical Supplies			x			
Compound Drugs				x		

* Do not require submission of abortion form. The hysterectomy and sterilization forms may be submitted at any time. When received the information is entered as a global service authorization allowing all associated claims to be processed.

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

6. List any other attachment types not mentioned above that you frequently request.

Authorization letter for eligibility exams
Authorization forms for Special Programs funded from all state monies, eg Family Preservation services, Catastrophic care etc.

7. Do you usually receive attachment document at your request after the claim is received (solicited) or with the submission of the claim (unsolicited)? (PICK ONE)

	Solicited
x	Unsolicited
	Both

8. What are the reasons you typically require attachments? (MARK ALL THAT APPLY)

	Federal Mandate
	State Mandate
x	Medical Policy
x	Federal or State Reporting Requirement
	Fraud and Abuse Mitigation
	Quality Measurements
	Pay for Performance Measures
x	Other, Please state: Unlisted and pay by report/cost invoice procedure codes.

NMEH Claims Attachment Survey – Attachment Statistics

December 2005

9. How does your organization typically store the attachment documentation that is submitted today? (FOR EACH TYPE MARK CATEGORY THAT FITS BEST)

Method of Storage	Almost Always	Frequently	Sometimes	Rarely	Never	N/A
Scan and Save as Image	x					
Scan and Save as Text via OCR						
Save as Paper						
Manually Key Data from Hard Copy			x			
Save in Other Electronic Media (word, pdf, etc)						
Discard/Destroy the Paper	x					

Submitter : Ms. Denise Love
Organization : National Association of Health Data Organizations
Category : Other Association

Date: 01/20/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-93-Attach-1.PDF

NAHDO

NATIONAL ASSOCIATION OF HEALTH DATA ORGANIZATIONS

Improving Health Care Data Collection and Use Since 1986

January 20, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

RE: [CMS-0050-P] HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments; Proposed Rule (70 Federal Register 55990) September 23, 2005.

Dear Dr. McClellan:

The National Association of Health Data Organizations (NAHDO) supports the development of national clinical data standards to enhance established administrative (billing or claims) systems. The immediate mechanism for integrating administrative (billing or claims) and clinical data is the claims attachment. NAHDO recognizes that a Claims Attachment final rule can be a nationally recognized solution for defining additional standard clinical data content to augment today's administrative (billing or claims) systems. This integration can improve the next generation of patient safety and quality outcome measures.

About NAHDO

NAHDO is a national non-profit membership and educational association dedicated to improving the collection and use of health care data and promoting the public availability of these data for research, market, and policy applications. NAHDO represents states collecting hospital and payer administrative (billing or claims) data and its members have long been industry leaders using that data for diverse uses. Emerging policy trends, driven by consumer and transparency reporting laws, are to develop patient safety and quality outcome measures for public reporting and quality improvement uses.

NAHDO understands the value of administrative (billing or claims) data and promotes enhancement of these data resources with clinical information for public health and quality measurement. This integration of clinical data with already existing administrative (billing or claims) systems are an efficient and cost-effective approach to

develop the next generation of patient safety and quality outcome measures. A foundation for this approach is in place:

- Over 45 states maintain a statewide all-payer, all patient hospital reporting system;
- NAHDO in cooperation with the Public Health Data Standard Consortium and the Agency for Healthcare Research and Quality have been responsible for the development of the Health Care Services Data Reporting guide to support state fields for broad applications of discharge data;
- NAHDO member states are actively combining administrative (billing or claims) and clinical data for infection and outcomes reporting, thus providing models for other states to implement similar reporting approaches.

About the Health Care Service: Data Reporting Guide

The premise of this ANSI ASC X12 approved 837-based implementation guide was that using the same federally mandated data and content standards would ease reporting burdens on hospitals and would also improve the ability of states to compare data amongst themselves. The 4050 (October 2001) version of the Health Care Service: Data Reporting implementation guide is an approved ANSI ASC X12 standard. Work is currently in progress to update the guide along with the sister HIPAA 837-based institutional, professional, and dental implementation guides based on the 5010 (October 2003) version of the ANSI ASC X12 standards.

Quality and Outcomes Reporting by States

The patient safety and quality outcome measures derived from the 837 reporting standard would consequently be more meaningful for cross state comparison. Increasingly, NAHDO members are currently championing the use of administrative (billing or claims) and clinical data to alert the healthcare community of the cost and the impact that hospital acquired infections have on our health care system. These infections are preventable and expensive. Having a national standard for the underlying data source is critical.

NAHDO recognizes that a Claims Attachment final rule would be the nationally recognized solution for defining additional clinical data content to augment today's administrative systems. Such a final rule would direct how future vendor systems would be developed. These same vendor systems are also the source of data for NAHDO members. It is clear to NAHDO that the entire industry is in need of integrating clinical and administrative (billing or claims) systems to improve the quality of health care in this country. That is why NAHDO feels it is important to comment on the Claims Attachment NPRM and why NAHDO strongly supports the efforts by the Department of Health and Human Services to establish a national standard to integrate clinical and administrative (billing or claims) data content.

The National Association of Health Data Organization (NAHDO) appreciates the opportunity to comment on the Proposed Rule of September 23, 2005, regarding the Standards for Electronic Health Care Attachments.

Highlights of the NADHO Claims Attachment NPRM Response

- NAHDO strongly supports language in the Claims Attachment Final Rule that would support the capability to transmit solicited AND unsolicited transmissions. NAHDO member systems would predominately use the unsolicited option to integrate clinical and administrative data for public reporting and quality improvement. We do not think this would allow for unlimited authority for data collection, because NAHDO member systems all restrict data reporting by state law, state regulations, or state instructions. That would also be true for the collection of any additional clinical data transmitted to states via a claims attachment process.
- NAHDO understands the complexity of the privacy issues, since each state member has their own rules and regulations that apply to data dissemination policies. It makes in even more imperative that the Claims Attachment Final Rule allows for the "right amount of data" to be collected. To facilitate that we encourage the development a detailed guidance document on the applicability of the Privacy Rule to the submission of claims attachment information by the Department of Health and Human Services. NAHDO believes the country is at greater risk without appropriate access to health data than the threat of privacy violations might present.
- NAHDO supports the establishment of a more responsive standards process to meet the emerging information needs of the current dynamic health care environment. The current HIPAA standards process is cumbersome, especially for emerging issues, thus encouraging states to develop unique, non-standard solutions to meet these needs.

NAHDO would like to comment the HL7 and ANSI ASC X12 for the cooperative effort in developing a much needed national standard for claims attachment.

The comprehensive NAHDO responses to the Claim Attachment NPRM are included below.

If you have any questions or concerns about the comments presented here, you may contact me at (801) 587 - 9118 or dlove@nahdo.org.

Sincerely,



Denise Love
Executive Director

NAHDO Comments

Definitions (Pages 55993 and 55994)

NAHDO is in agreement with the definitions of the terms as stated in the preamble of the proposed rule and Section 162.1900 of the regulation text.

We believe there are differences in the way terms are described in the preamble text and defined in the text of the rules. We strongly recommend reviewing the preamble description of all definitions and conforming them to the actual text of the rule.

Effective Dates (Page 55994)

NAHDO finds the timeframe outlined to be adequate for the implementation of the claims attachment transaction. We support the discussion in the NPRM that relates to covered entities having already implemented the other X12 transactions, acquired translators etc. We believe that since this standard is being implemented as the second-round of transaction standards, some of the infrastructure should already be in place. Based on this premise, we expect secondary uses of these standards to support the needs of NAHDO members will also utilize the infrastructure created to comply with HIPAA mandates. Using the standard provider infrastructure will enable more timely implementations of state reporting systems needing additional clinical data in the future.

Overview of Clinical Document Architecture (Page 55995)

NAHDO supports the use of an established data standard for messaging clinical data. We will support the decision by HL7 on what they determine to be the best release for the industry as long as the necessary functionality for anticipated future state reporting needs and a recognition that each state's unique circumstances can also be accommodated by that same standard.

Transactions for Transmitting Electronic Attachments (Page 55996)

NAHDO strongly supports the use of structured, as opposed to unstructured, content in electronic data interchange and we believe that the HL7 standards provided this much needed structure.

We recommend that the language clarifying that the Binary Data (BIN) segments use of structured data using the HL7 CDA standard. It should be clear that both the human decision and computer decision variant data are contained in a CDA message.

We strongly support the use of the proposed X12 transactions for the transmission of electronic attachments:

- X12 277 for the electronic transmission of a request for claim attachment information

- X12 275 for the electronic transmission of a response to a claim attachment request for information

We strongly recommend the adoption of version 5010 of the propose X12 transactions, rather than the version 4050, as proposed in the NPRM.

Electronic Claims Attachment Types (Pages 55996 and 55997)

The NPRM is proposing 6 types of claims attachments – ambulance services, emergency department, rehabilitation services, clinical reports, laboratory results, and medications. We support and recommend that the final rule name some or all of these claims attachment types to establish a floor for the legislation, but that a process be developed by DHHS to allow industry consensus through existing HL7 processes for establishing future attachment types deemed necessary through industry outreach. Unless such a process is developed, we do not believe the claims attachment process can be responsive enough to future industry needs in a timely enough fashion.

NAHDO strongly supports the language included in the proposed rule that new electronic attachment standards approved by the SDO but not adopted by the Department may be used on a voluntary basis between trading partners. We would like to think that the NPRM is setting a floor for the use of attachment transactions and not a ceiling. This will also encourage non-HIPAA uses of the proposed electronic claims attachment process using mandated national standards.

Format Options (Human vs. Computer Variants) for Electronic Claims Attachments (Pages 55997 and 55998)

NAHDO strongly supports the flexibility being allowed in the proposed rule for using either the human or computer decision variant options of the HL7 CDA.

We believe the more flexible option provides necessary functionality for the solutions proposed in this NPRM to meet current and future industry needs. We also believe the auto-processing capabilities possible through use of the computer decision variant should be encouraged over the long term.

Combined Use of Two Different Standards Through Standard Development Organization (SDO) Collaboration (Page 55998)

NAHDO strongly supports the use of standards for electronic data interchange, versus non-standard approaches. We support the collaborative efforts of HL7 and X12 in developing the format and content of the transactions in this proposed rule.

Electronic Health Care Claims Attachment Business Use (Pages 55998 and 55999)

NAHDO supports, in terms of regulation, that the transactions outlined in this proposed rule should be used for the claims adjudication process and auto-processing processes for alternate uses of the proposed standards and process. We also encourage voluntary use of the standards for post-adjudication or reporting uses of the

related transactions. We support the need-to-know concept of “collect once, use a lot.”

Electronic Health Care Claims Attachment vs. Health Care Claims Data (Page 55999)

The NPRM includes statements that the attachments must not be used to convey information that is already required on every claim and the purpose of the attachment is to convey supplemental information. Since the data needs for state reporting systems often overlap claim uses of the data, NAHDO strongly encourages guidelines be established to define standards for the clinical and administrative (billing or claims) content. This national oversight is necessary to harmonize the data collected, which will minimize the burden these additional data requirements could potentially have on the industry.

In the NPRM, it is said that “Electronic health care claims attachments must not be used to convey information that is already required on every claim. Information needed for every claim is “claims data” that must be conveyed in the appropriate standard claim transaction.” Furthermore, in the actual propose rule text (page 56024) § 162.1905(a) states “...information not contained in a health care claim is needed for the adjudication of that health care claim:...”

We request clarification as to the use of the term ‘every’ in both sentences. We are concerned that the industry is still somewhat struggling to determine what a valid and complete 837 is, it will be even more challenging to define what data is or isn’t claim data. There is also the difference between data when a claim is submitted electronically versus paper, and neither the rule text nor the text in the preamble seem to address these data content differences.

Also, we believe the use of the words “not contained” in the actual rule text, same as above, creates ambiguity with the required vs. situational data conditions used in the electronic transactions.

Solicited vs. Unsolicited Electronic Health Care Claims Attachments (Page 55999)

The NPRM is proposing that providers may submit an unsolicited electronic attachment with a claim only when a health plan has given them specific advance instructions pertaining to the type of claim or service. Most state reporting systems as they exist today would use the unsolicited option, because the additional data needs are typically included in state rules and regulations that provide authority for these state systems. Therefore, NAHDO strongly supports the capability to transmit solicited AND unsolicited transmissions. The requirement for prior agreement for use of unsolicited messages would be consistent with current state practices.

Impact of Privacy Rule (Pages 55999 and 56000)

NAHDO believes that the Department of Health and Human Services (HHS) needs to provide more Formal guidance on the impact of privacy in the specific areas of "minimum necessary" and patient's rights.

Thus, we strongly recommend that the Office for Civil Rights developed a detailed guidance document on the applicability of the Privacy Rule to the submission of claim attachment information, with illustrative examples based on real-case analysis. Guidance should include a description of how patient rights (including access and restriction) and cover entity responsibilities (including minimum necessary) will impact claim attachment information for the submitter and the recipient.

We believe there needs to be a balance between the patient's right to privacy and the ability for the provider to respond to a request for additional information, specifically as it relates to the use of scanned documents within the attachment. In addition, the NPRM does not address the recipients' maintenance of the data and use of the data under which the rule applies.

To frame the discussion on privacy issues, it is important the federal rules allow for the "right amount of data" to be collected. ("Goldilocks Principle.")

Impact of the Security Rule (Page 56000)

NAHDO believes that any efforts to comply with the Security Rule should be effectively incorporated into electronic attachment processing. With this new standard, there is a need for HHS to provide further guidance to the industry to help with understanding the additional concerns on security, as well as privacy, specific to the claims attachment process.

Connection to Signatures (Hard Copy and Electronic) (Page 56000)

NAHDO supports the acceptance of a response code indicating "signature on file."

Electronic Health Care Claims Attachment Content and Structure (Pages 56001 and 56002)

NAHDO does not have the expertise to recommend the amount of data permitted in a transaction. We do support that all potential senders and receivers of the data be required to adhere to the maximum size allowed in the final rule.

Proposed Standards (Page 56004)

NAHDO supports the HL7 and X12 standards, as named in the preamble and Section 162.1915 of the regulatory text. The X12 standards request and response transactions coupled with the HL7 messaging structures appear to represent the best electronic solution for exchanging additional information for a wide range of uses.

Consistent with our opinion that these regulations set a floor not a ceiling for future industry needs, we support the naming of transaction standards and versions in this

final rule. We also believe the language in the final rule should allow for future versions based on industry consensus and HL7 and X12 standards approval processes for future versions without the burden of another federal rule making process that would enable the standards to satisfy future industry needs in a timely fashion. The final rule should specify the time interval for acceptable version changes to provide a balance between the burden of change and the need to respond to industry needs.

Code Set (Page 56004)

NAHDO supports the adoption of LOINC as the code set for representing the specific elements of attachment information. We believe to enable auto-processing of the data it is necessary to codify the data. We realize that this use of LOINC is not fully tested, but believe this solution should move forward with the rest of the claims attachment process in lieu of a better option at the present time.

We strongly encourage more continued testing of the use of LOINC codes to support a structured solution. With that said, however, we have concerns about the lack of a defined timeline for when changes/updates to the code set will be in effect for the industry (as it is the case for all other external code sets). We also recommend that education be made available to standardize how the code set should be used for claims attachments.

Electronic Health Care Claims Attachment Response Transaction (Pages 56005 and 56006)

The NPRM is requesting input on other types of claims attachments that impact the health care industry.

NAHDO supports the NUCC and NUBC recommendation that HHS develop a process to track the utilization of the named and any unnamed attachment types to determine which attachment types are most needed by the health care industry, as well as state currently engaged in quality outcome initiatives.

Modifications to Standards and New Electronic Attachments (Page 56013)

We are aware of concerns in the health care industry regarding the length of time it takes to adopt or modify a standard through the current regulatory process. We would like to see the process move more quickly to allow for more timely adoptions and modifications to better meet the needs of the industry. We propose that for adopting new attachment types that the DSMOs be authorized to adopt them through the DSMO process after they have been developed, balloted, and published by HL7. The standards would not then go through the regulatory/NPRM steps. In addition, the DSMOs would be authorized to adopt new versions of existing attachment types after they have been modified, balloted, and published by HL7. Again, the modified standards would not go through the regulatory/NPRM steps. The proposed processes would include provisions for industry outreach and comments through the HL7 SDO procedures. To support this change in procedures, the DSMO would need to develop a notification and roll-out process.

We would also like to have language added to the final rule emphasizing the need for further education to the industry about the process for requesting changes to the adopted standards.

Regulatory Impact Analysis (Page 56014)

NAHDO does not have specific information related to the business costs and/or savings for implementing the claims attachment transactions. We have, however, encouraged our constituents to respond with any data that they may have.

Section 162.1920 (Page 56024)

NAHDO agrees that the claims attachment standard be robust enough to support the capability for requested information to be full text, scanned, or imbedded in the BIN segment in accordance with HL7 CDA standards.

Submitter : Ms. Dyan Anderson

Organization : QuadraMed

Date: 01/20/2006

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Ms. Stephanie Piel
Organization : Hinman Straub
Category : Health Plan or Association

Date: 01/20/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-0050-P-96-Attach-1.PDF

**HINMAN
STRAUB** 
ATTORNEYS AT LAW

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January 20, 2006

VIA E-MAIL & FIRST CLASS MAIL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

Rc: CMS-0050-P, Standards for Health Care Claims Attachments

To Whom It May Concern:

Thank you for the opportunity to provide comments on the proposed rule, HIPAA Administrative Simplification: Standards for Electronic Health Care Claims Attachments. Our comments on behalf of Excellus Health Plan, Inc., are as follows:

II. H. Requirements (Health Plans, Covered Health Care Providers and Health Care Clearing Houses).

The proposed rule would permit health plans to send requests for health care claims attachments either manually or electronically. However, the health plan would be required to send the health care claim attachment request electronically if requested to do so by the health care provider.

It would be administratively burdensome for health plans to track the method by which particular providers prefer to receive requests for health care claims attachments. We suggest CMS consider the alternate approach of tying the method by which health care claims attachments are transmitted to the method by which the original health care claim is transmitted. This means that when a health care provider submits an electronic health care claim to a health plan, the health care claim attachment would also be transmitted electronically. The reverse would apply for manual submission of health care claims. (The claims attachments would likewise be transmitted manually). Another way of

characterizing this method is to "deem" the submission of an electronic claim a request by the provider for an electronic claim attachment request.

Again, thank you for the opportunity to provide comments on the proposed rule. Please do not hesitate to contact me should you have any questions.

Very truly yours,

A handwritten signature in cursive script, reading "Stephanie A. Piel". The signature is written in dark ink and is positioned above the printed name.

Stephanie A. Piel

Submitter : Mrs. Anita Buescher

Organization : Sutter Health

Date: 01/20/2006

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-97-Attach-1.PDF



Sutter Health

With You. For Life.

Office of the General Counsel

Ethics & Compliance Services

Legal Services

January 18, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P
P.O. Box 8014
Baltimore, MD 21244-8014

RE: CMS-005-P, Administrative Simplification: Standards for Electronic Health care Claims Attachments; Proposed Rule September 23, 2005

Dear Sirs:

On behalf of Sutter Health, a Northern California not-for-profit network of more than two dozen acute care hospitals as well as physician organizations, home health, hospice, occupational health networks and long-term care centers, we appreciate this opportunity to comment on the proposed rule on standards for electronic health care claims attachments (Federal Register/Vol 70, No. 184/September 23, 2005).

The proposed standards introduce new requirements that are not widely used in current billing processes. To ensure optimal implementation these new requirements will require budgeted funds, new knowledge and training, and sufficient time for testing and implementation. Given the many other priorities and requirements that health care institutions face today we believe two years will not be adequate time for implementation. We suggest that a contingency period of 2-4 years be allowed so impacted covered entities have sufficient time to prepare.

While our providers see many advantages to being able to provide claims attachments electronically there is concern that payers will not implement the regulation requirements consistently and within required time frames, resulting in non-standard processes, delays in payment, and increased administrative costs.

In addition to these general observations we offer the following detailed comments to specific sections of the proposed rule:

COMBINED USE OF DIFFERENT STANDARDS

The creation of a combination of ANSIx12 and HL7 is a new requirement, which to our knowledge, has never been attempted before. The structure and the data flow of HL7 does not lend itself to the storage and capture of information for resending on demand. There is the potential in using HL7 to flood other systems with unwanted information. Within our organization HL7 is used for the real time transfer of clinical information. A clinical repository stores historical information but there is no current methodology to capture that information and send it to a vendor or a payer. To create this functionality is

very costly and will require more than the allotted two years for implementation. We recommend that a single format be adopted and enhanced if needed and suggest that the best option is the ANSI X12 277/275 standard.

Regarding the statement that "electronic health care claims attachments must not be used to convey information that is already required on every claim" (page 55999), it is not clear how these data elements will be defined. Specifically it would be helpful to know which fields on the UB92 or UB02 cannot be duplicated. Currently payers request copies of insurance ID cards in order to obtain the plan ID number, even though this number is already on the claim. Providers are concerned that ID cards may become a "future" attachment so that payers can continue the practice of requesting copies of ID cards.

FORMAT OPTIONS

Clarification is being sought on the ability to continue to send the attachments covered by these proposed regulations through an automated fax capability without using HL7.

SOLICITED VS UNSOLICITED ATTACHMENTS

Contracts with payers have been negotiated so that attachments are provided "after" payment of the claim. Will these regulations preclude this from occurring in the future? Must attachments that have the potential to impact payments already made and that are provided on a post-payment basis meet these attachment standards?

Health care providers currently identify patterns of claims attachment requests from specific payers and automatically provide these attachments with the claim in order to expedite payment. Under the proposed regulations this would not be allowed unless the payer has requested an "unsolicited" attachment. Our providers are concerned that payers could delay payment of a claim by waiting until after claim submission to solicit this information, even though the same information is requested routinely for specific types of claims.

Because some claims attachments will continue to be requested non-electronically there is concern that operationally it will be difficult for payers to match electronic claims and electronic attachments with attachments submitted in paper. This has the potential for further delaying payments to providers and to actually increasing duplicate requests for the same information.

Our providers also desire clarification on whether they can continue to submit claims electronically if they find it impossible to submit one of the specified attachments electronically.

MINIMUM NECESSARY

Health care providers who choose to submit attachment information in the form of scanned documents will need to ensure that those documents do not contain more than the minimum necessary information. (Page 56000). It would be burdensome for providers to remove portions of scanned documents as this necessitates copying the document, redacting the unnecessary information, and then recopying the document for scanning. The decision regarding which information to redact is arbitrary and not generally made by staff with clinical backgrounds. We suggest that sending the entire page of the document that contains the requested information meets the "reasonableness" standard of the regulations.

ATTACHMENT CONTENT AND STRUCTURE (Page 56001)

ANSI X12 275 permits up to 64 megabytes of data in a single transaction. Inbound HL7 will accept a packet 32 megabytes in size. We suggest that the data in a single transaction for a claims attachment be limited to 32 megabytes.

MODIFICATIONS TO STANDARDS AND NEW ATTACHMENTS (Page 56013)

There is currently no functionality in our systems for the use of LOINC codes. This requires a rewrite of current systems in order to build master tables, update master tables, create fields to store LOINC codes and create the capability to process LOINC codes. This requirement has significant budget and operational impact. Two years to meet these requirements will not be sufficient.

This concludes our comments. Thank you for the opportunity to provide input on these proposed regulations.

Sincerely,

Anita Buescher, RHIA, CHP

Anita Buescher, RHIA, CHP
Sutter Health Privacy Officer
Ethics and Compliance Division
Office of General Counsel
Sutter Health

2200 River Plaza Drive
Sacramento, CA 95833

Submitter : Grace Upleger
Organization : Vanderbilt University Medical Center
Category : Health Care Provider/Association

Date: 01/20/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-0050-P-98-Attach-1.DOC

Vanderbilt University Medical Center



20 January 2006

TO:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0050-P

via: Electronic Comments @ <http://www.cms.hhs.gov/regulations/ecomments>

References: 70 FR 184, 9/23/2005, pages 55989-56025

Following are written comments on the proposed rule for HIPAA Administrative Simplification Standards for Electronic Health Care Claims Attachments from Vanderbilt University Medical Center. Most of these comments were derived from the VUMC Claims Attachment team. Compilation by Grace Upleger.

Comment Number: Vanderbilt - 1

Criterion: PROVIDERS WANT CERTAINTY OF FORMAT AND CONTENT FOR WHAT THEY MUST TRANSMIT

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.01)

- Health care providers want single straight-forward precise implementation specifications that direct them on what to send, under what situations, and using a precise format.
- Health care providers want these single implementation specifications to be independent of any and all actual or potential recipients. Health care providers do not want to have to contact or be contacted by each potential recipient to determine or negotiate anything at all regarding what they are to send.
- Health care providers certainly don't want to have to send different contents or different formats to different receivers based on any trading partner agreements or other multiple sender-receiver pair "companion guides".

Comment Number: Vanderbilt - 2

Criterion: **ADDITIONAL INFORMATION SPECIFICATION 0002:
EMERGENCY DEPARTMENT ATTACHMENT**

- The following LOINC's are either: 1)not captured now for billing, 2)are not collected in our systems, or 3)are at least partially captured on paper and thus we request that they be removed from the available LOINC's:
 - 11459-5 EMS SYSTEM, TRANSPORT MODE
 - 18704-7 PROVIDER, ED REFERRING PRACTITIONER
 - 11319-1 EMS SYSTEM, TRANSPORT UNIT IDENTIFIER
 - 11318-3 EMS SYSTEM, TRANSPORT AGENCY IDENTIFIER
 - 11293-8 ED REFERRAL, SOURCE
 - 11454-6 FIRST RESPONSIVENESS ASSESSMENT
 - 11324-1 FIRST GLASGOW SCORE EYE OPENING
 - 11326-6 FIRST GLASGOW SCORE VERBAL
 - 11325-8 FIRST GLASGOW SCORE MOTOR
 - 18690-8 FIRST BODY WEIGHT
 - 11372-0 INJURY, ACTIVITY ASSOCIATED WITH
 - 11457-9 INJURY, SAFETY EQUIPMENT USED DURING
 - 18617-1 MEDICATIONS ED DISCHARGE

Comment Number: Vanderbilt - 3

Criterion: **ADDITIONAL INFORMATION SPECIFICATION 0006 :
MEDICATIONS ATTACHMENT**

- The following LOINC's are either: 1)not captured now for billing, 2)are not collected in our systems, or 3)are at least partially captured on paper and thus we request that they be removed from the available LOINC's:
 - 19013-2 MEDICATIONS CURRENT REPORT
 - 19014-0 MEDICATIONS DISCHARGE REPORT
 - 19015-7 MEDICATIONS ADMINSTERED REPORT

Comment Number: Vanderbilt - 4

Criterion: **ADDITIONAL INFORMATION SPECIFICATION 0004:
CLINICAL REPORTS ATTACHMENT**

- The following LOINC's are either: 1)not captured now for billing, 2)are not collected in our systems, or 3)are at least partially captured on paper and thus we request that they be removed from the available LOINC's:
 - 28581-7 CHIROPRACTOR INITIAL ASSESSMENT General
 - 28580-9 CHIROPRACTOR PROGRESS NOTE General
 - 18762-5 CHIROPRACTOR VISIT NOTE General
 - 28622-9 NURSE HOSPITAL DISCHARGE ASSESSMENT General
 - 29753-1 NURSE INITIAL ASSESSMENT General
 - 28623-7 NURSE INTERVAL ASSESSMENT General
 - 28651-8 NURSE TRANSFER NOTE General
 - 28621-1 NURSE-PRACTITIONER INITIAL ASSESSMENT General
 - 18734-4 OCCUPATIONAL THERAPY INITIAL ASSESSMENT General
 - 11507-1 OCCUPATIONAL THERAPY PROGRESS NOTE General
 - 28578-3 OCCUPATIONAL THERAPY VISIT NOTE General
 - 18735-1 PHYSICAL THERAPY INITIAL ASSESSMENT General
 - 11508-9 PHYSICAL THERAPY PROGRESS NOTE General
 - 28579-1 PHYSICAL THERAPY VISIT NOTE General
 - 18737-7 PODIATRY INITIAL ASSESSMENT General
 - 28624-5 PODIATRY OPERATIVE NOTE Specific (similar to 3.3.2)
 - 28625-2 PODIATRY PROCEDURE NOTE General
 - 11509-7 PODIATRY PROGRESS NOTE General
 - 11488-4 PROVIDER-UNSPECIFIED CONSULTING NOTE General
 - 15507-7 PROVIDER-UNSPECIFIED ED VISIT NOTE General
 - 11492-6 PROVIDER-UNSPECIFIED HISTORY AND PHYSICAL NOTE Specific 3.3.3
 - 28574-2 PROVIDER-UNSPECIFIED HOSPITAL DISCHARGE SUMMARY General (similar to 3.3.1)

- 28636-9 PROVIDER-UNSPECIFIED INITIAL ASSESSMENT General
- 11504-8 PROVIDER-UNSPECIFIED OPERATIVE NOTE Specific 3.3.2
- 28570-0 PROVIDER-UNSPECIFIED PROCEDURE NOTE General
- 11506-3 PROVIDER-UNSPECIFIED PROGRESS NOTE General
- 18740-1 SPEECH THERAPY INITIAL ASSESSMENT General
- 11512-1 SPEECH THERAPY PROGRESS NOTE General
- 28571-8 SPEECH THERAPY VISIT NOTE
- 11528-7 RADIOLOGY UNSPECIFIED MODALITY AND SITE STUDY Specific
- 18782-3 X-RAY UNSPECIFIED SITE STUDY Specific
- 28613-8 X-RAY SPINE UNSPECIFIED, STUDY Specific
- 18747-6 CT UNSPECIFIED SITE, STUDY Specific
- 18755-9 MRI UNSPECIFIED SITE, STUDY Specific
- 18757-5 NUCLEAR MEDICINE UNSPECIFIED STUDY Specific
- 18758-3 PET SCAN UNSPECIFIED SITE, STUDY Specific
- 25043-1 CT GUIDANCE FOR ASPIRATION OF UNSPECIFIED SITE, STUDY Specific 3.4.7
- 25044-9 CT GUIDANCE FOR BIOPSY OF UNSPECIFIED SITE, STUDY Specific
- 25069-6 FLUOROSCOPIC GUIDANCE FOR BIOPSY OF UNSPECIFIED SITE, STUDY Specific
- 25059-7 ULTRASOUND GUIDANCE FOR BIOPSY OF UNSPECIFIED SITE, STUDY Specific
- 18760-9 ULTRASOUND OF UNSPECIFIED SITE, STUDY Specific
- 28615-3 AUDIOLOGY STUDY General
- 29756-4 PERITONEOSCOPY STUDY
- 28620-3 UROLOGY STUDY General

Comment Number: Vanderbilt - 5

Criterion: **ADDITIONAL INFORMATION SPECIFICATION 0003:
REHABILITATION SERVICES ATTACHMENT**

- The following LOINC's are either: 1)not captured now for billing, 2)are not collected in our systems, or 3)are at least partially captured on paper and thus we request that they be removed from the available LOINC's:
 - 27676-6 PHYSICAL THERAPY TREATMENT PLAN, DATE ATTENDING MD REFERRED PATIENT FOR TREATMENT
 - 27613-9 OCCUPATIONAL THERAPY TREATMENT PLAN, DATE ATTENDING MD REFERRED PATIENT FOR TREATMENT

(This data is available with the physician's referral for therapy but not contained in the 700/701 or equivalent document).
- There is a potential discrepancy with Attending physician signature and Therapist signature since signatures are collected both electronically and by hard copy in many sites. Does a scanned electronically signed document receive credit for signature or would this have to be accompanied by the hospital's electronic signature file?
 - 27677-4 PHYSICAL THERAPY TREATMENT PLAN, DATE ATTENDING MD SIGNED
 - 27679-0 PHYSICAL THERAPY TREATMENT PLAN, SIGNATURE OF RESPONSIBLE ATTENDING MD ON FILE

- Since 700/701 forms or equivalent documents (evaluation/progress documents containing same content as 700/701) are industry standards and would be likely utilized for the Scanned documents for Human Decision Variants; LOINC responses utilized should match 700/701 fields descriptions.

Comment Number: Vanderbilt - 6

Criterion: MORE EXPLANATION IS NEEDED REGARDING THE RESTRICTIONS BEING PLACED ON PROVIDERS SUBMITTING UNSOLICITED ATTACHMENTS

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.07)

- No such restrictions or requirements for advance instructions presently exist for paper attachments that providers routinely send along with paper claims because they know from experience that they are needed to obtain timely payment. Notwithstanding the discussion on page 55999 of this NPRM, wouldn't the same rationale apply to electronic attachments?
- Alternatively, if such advance coordination is really needed, suggest that this NPRM be modified to allow providers to send at any time descriptions of certain types of claims, procedures, or services for which they might send unsolicited attachments, and, unless or until each health plan specifically case-by-case objects in writing, such unsolicited attachments must be received and appropriately processed.

Comment Number: Vanderbilt - 7

Criterion: EFFECTIVE DATES

(We are seconding portions of the comment that the AHA made on 11-22-05 – regarding Effective Dates (pg 55994))

- The proposed rule calls for implementation to begin two years after the final rule for all covered entities except small health plans, which have an additional year.
- We recommend a three-year implementation period to allow providers sufficient time to budget, train and test these standards. We further

suggest CMS consider a staggered implementation schedule with specific sequencing of the attachment standards mentioned in the proposed rule. Hospitals have indicated that an orderly progression for each of the attachment standards would also be best for all parties.

Comment Number: Vanderbilt - 8

Criterion: PROVIDERS WHO HAVE ALREADY INVESTED IN HL7
DON'T WANT TO BE FORCED TO USE ANOTHER
VARIANT OF HL7

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.03)

- In spite of several years of marketing and entreaties, United States health care providers who are already using HL7 version 2 series messages have almost universally declined to convert to HL7 CDA. This decision is economic: CDA provides essentially no additional functionality over what is already being achieved using HL7 version 2.
- Moreover, HL7 version 2 isn't broken – just not as new as CDA and XML. Unfortunately, this NPRM would force these health care providers to expend resources to add use of CDA only for claims attachments – without converting their other HL7 interfaces. As a consequence, use of CDA for claims attachments adds an additional interfacing methodology for these providers – with its attendant ongoing costs of operation in addition to the start-up costs noted in this NPRM. The same discussion applies equally to the creation of Human Decision Variant transactions instead of just continuing to use HL7 version 2 standard data element messages.

Comment Number: Vanderbilt - 9

Criterion: PROVIDERS DO NOT WANT THE PAYERS TO DECIDE
WHICH VARIANT THE PROVIDERS SHOULD SUBMIT
WITH – THIS HAS TO BE THE PROVIDER'S
DECISION.

(We are seconding portions of the comment that the AHA made on 11-22-05 – Format Options -- Human vs. Computer Variants (pg 55997))

- The AHA recommends that the final rule clearly states that a hospital may use any one of the three variants and that a health plan cannot force a hospital to use one variant over another. A health plan that is not ready to use the computer decision variant can still convert this format to a human decision variant.

Comment Number: Vanderbilt - 10

Criterion: HUMAN DECISION VARIANTS NEED EXPLICIT SPECIFICATIONS THAT OVERCOME THE UNSTATED ASSUMPTIONS ON WHICH THEY ARE BASED

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.04 and of the AHA, 11-22-05, Impact of Privacy Rule (pg 55999))

- Providers want clear mandates on what will be a successful transmission of images. What is a good quality image that is decipherable? Could there be a standard put in place so that payers and providers alike would know what to transmit and what to expect?
- Moreover, it also seems to be presumed that scanned images are of only machine-created documents – are handwritten documents and sketches be imaged and then transmitted?
- Health care providers are conscious of the HIPAA Privacy rule, but do believe that submitting 1 page of scanned data that has the appropriate requested LOINC information AND additional data should meet the reasonableness factor. This has to be clear in the rule. The AHA indicated in their comments on the Impact of the Privacy rule that: “We would appreciate further clarification around the term “reasonable efforts,” especially when a provider receives a request for information and the relevant document contains unrelated information. It would be burdensome for a provider that adopts the human decision variant of a scanned image to edit the document to remove sections not requested. It would be “reasonable” for the provider to scan and send the entire page of the document as long as it contains the information requested by the health plan.”
- There are no specifications for how some Human Decision Variant files are themselves to be formatted. As but one example, are PDF files to be sent as text or with embedded scanned images? Both of these techniques are commonly in use.

Comment Number: Vanderbilt - 11

Criterion: ATTACHMENT DATA SHOULD NOT BE REQUESTED BY PAYORS THAT IS ALREADY AVAILABLE ON THE 837

(We are seconding portions of the comment that the AHA made on 11-22-05 – Electronic Claims Attachment Types (pg 55996-7))

- The ambulance and rehabilitation therapies attachment types include many data elements that are on the institutional claim. For instance, institutional-based ambulances report miles traveled as a revenue code within the UB-92 data set and in the SV2 segment of the 837 (institutional) claim transaction. Similar reporting occurs for plan of treatment dates and visits. Typically, these items are occurrence codes or value codes contained in the HI segment in the 837. We recommend reporting these data items within the institutional claim standard rather than in an attachment transaction.
- **The claim attachment should be used only as a supplement to the claim.** If information is part of the institutional OR professional claim, a health plan should not request the same information in a claim attachment. Health plans must be prepared to handle the entire range of data elements that comprise the claim standard. Failure to do so would be a compliance violation on two fronts: they are unprepared to use the information reported in the claim standard; and they are misusing the attachment standard by asking for information contained in the claim.

Comment Number: Vanderbilt - 12

Criterion: CAN OTHER STANDARDS BE CONSIDERED INSTEAD OF THE LOINC CODE SET?

- Our current EMR and billing systems do not store or pass LOINC codes now. We would much rather have codes that our systems recognize if we are to receive requests from payers via these codes. We know that the NPRM indicates that: "On May 6, 2004, the Secretaries adopted standards for 20 domains and subdomains; among others, these included: HL7 messaging standards for clinical data, NCPDP standards for ordering from retail pharmacies, IEEE1073 to allow health care providers to monitor medical devices, DICOM to enable images of diagnostic information to be retrieved and

transferred between devices and workstations, LOINC for the exchange of clinical laboratory results, SNOMED CT for certain interventions, diagnosis and nursing terminology, and a variety of terminologies for medications.....There was virtually no depth in the pool of available code sets for consideration to request or send information—at least not one individual code set with everything that might be needed for electronic health care claims attachments. Thus, the original candidate for the code set to be used with attachments was the X12N version of health care claims status reason codes, tied to the X12N 837 claims transaction and the claims status inquiry and response (X12N 276/277).....Ultimately, the standards organization determined that the health care claims status codes were significantly less definitive and efficient than the LOINC codes for communicating detailed or specific clinical information to supplement a claim, and made a recommendation to the Secretary to adopt LOINC for the electronic health care claims attachment transactions” **Could not the health care claims status codes be updated to be more specific?**

Comment Number: Vanderbilt - 13

Criterion: A MUCH MORE ROBUST AND COMPLETE PILOT
MUST BE UNDERTAKEN BEFORE NPRM BECOMES
FINAL.

(We are seconding portions of the comment that Rensis Corporation/David Feinberg, CDP, made on 11-18-05 – Comment Number Rensis-90.03)

- The pilot project for this proposed rule showed failure of the process. 129 claim attachments processed successfully out of 222 requested in only a 58% success rate. Certainly I don't think we would consider it successful business here if only 58% of our disputed claims were even processed.
- In view of the failure rate CMS and the sponsors of this rule needs to stop and really review things before moving forward.
- This poor success rate came despite this pilot being funded by CMS (for the Empire piece) and having extra resources, extra technical support from vendors, etc. It also involved a very small set of providers and transactions. A true pilot given the typical hospital's constrained resources would probably have been less successful.
- What was the extra cost per claim attachment imposed on the providers to meet this rule as compared to their current methods? Added cost needs to be a factor in whether this rule moves forward – it may save payers money but prove extremely costly for providers to implement.
- The process and the costs of implementing the Computer Variant are not indicated in the pilot. A pilot should contain all attachment types, not just 2, to ensure the NPRM would work.

- The process and the costs of implementing an unsolicited 275 are not indicated in the pilot. A pilot should contain unsolicited 275's to ensure the NPRM would work.
- The costs of acquiring, installing, and updating software to create Human Decision Variant Non-XML files are not listed. As but one example, for PDF, Acrobat Reader is indeed free, but the software to create PDF (e.g., full Acrobat, Photoshop, InDesign) is not. Additionally, there could be recurring costs for software upgrades. Again, for PDF, Adobe can and sometimes does change the standard annually.
- The costs of acquiring, installing, and operating hardware (e.g., scanners, additional memory, cables, high speed communications lines, etc.) to use Human Decision Variant scanned images, and in some cases very large XML Computer Decision Variant files, are not listed. This is a particular concern for smaller providers.
- An estimate of the costs and other impacts of requiring health care providers and their vendors to implement and operate the completely new implementation specification paradigm – i.e., CDA – proposed in this NPRM needs to be performed.

Comment Number: Vanderbilt - 14

Criterion: DIAGNOSIS AND PROCEDURE CODES

(We are seconding portions of the comment that the AHA made on 11-22-05 – Electronic Health Care Claims Attachment vs. Health Care Claims (pg 55999))

- This section indicates that attachments not convey information that is already required on every claim; the purpose of the attachment is to convey supplemental information.
- We agree that the attachment standards should be limited to providing supplemental information only. When the claim standard includes specific codes to describe a particular event or situation then providers should use the claim standard to report this information; health plans must be able to process this information. Health plans must stay current with billing codes and build the necessary logic in their processing systems to recognize this information.
- Many health plans appear weak in handling the diagnosis and procedure codes reported in claims. The claim standard allows the provider to report up to 25 diagnoses and 25 procedure codes; however, many health plans, including Medicare, recognize and process only a small number of these codes. Some health plans have indicated that their claim adjudication systems only handle the first three codes. This is extremely problematic since a patient

with multiple co-morbidities or complications could easily require more than nine diagnosis or nine procedure codes to explain services provided for an episode of care. Health plans must have the ability to process and evaluate the entire number of clinical codes allowed on the claim standard. Otherwise, providers will receive requests for attachments that seek justification for the services that could have been derived if the health plans had the ability to process all of the clinical codes reported.

Submitter : Ms. Dyan Anderson

Organization : QuadraMed

Date: 01/20/2006

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.